ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-043085
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3244

FILED NOV 30 1961

1. PLACE OF DEATH
a. COUNTY St.Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St.Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton
Length of stay in 1b DOA
c. CITY OR TOWN Clayton
Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hosp.
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 7551 Byron
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First HARRY Middle Last ABRAMS
4. DATE OF DEATH Month Nov. Day 15 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 7/19/1912
9. AGE (last birthday) 49
IF UNDER 1 YEAR Months Days; IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10b. KIND OF BUSINESS OR INDUSTRY Retail Shoes
11. BIRTHPLACE (City and state or country) St.Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Abe Abramowitz
13b. MOTHER'S MAIDEN NAME Kate Liebert
14. NAME OF HUSBAND OR WIFE Naomi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) Yes (If yes, give war or dates of service) WW#2
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT Naomi Abrams Address 7551 Byron

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 1953, to 11/15/61 and last saw ~~her~~ him alive on 11/13/61
Death occurred at 10:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE Robert Potashnick M.D. (Degree or title)
22b. ADDRESS 3720 Washington
22c. DATE SIGNED 11/15/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Bur.
23b. DATE 11/16/61
23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol
23d. LOCATION (City, town, or county) Ladue Mo. (State)

24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 Mc'herson
25. DATE RECD. BY LOCAL REG. 11-16-61
26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No. 3988

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.